DRVD
CONFIDENTIAL REPORT

AN INVESTIGATION INTO ABUSE AND/OR NEGLECT

Seventy-one year-old Caucasian male resident of Heritage Hall Nursing Home, allegedly abused by staff.

DRVD CASE# 97-0386M
Department For Rights of Virginians With Disabilities
Fishersville Field Office
Beth Chadwell, Advocate
March 1998

I. INTRODUCTION

This report summarizes the findings of my investigation into the possible abuse and/or neglect of PQ, a 71-year-old, Caucasian male, while he was a resident at Heritage Hall Nursing Home ("HHNH") in Big Stone Gap, Virginia. PQ utilized a walker while he was a resident at HHNH and required staff assistance to move from his bed to his chair. He also required help from staff with bathing. On August 25, 1997 a HHNH staff person telephoned PQ's niece and reported that she found six bruises on PQ's chest and arm. On August 26, 1997, PQ's niece telephoned the Department for Rights of Virginians With Disabilities ("DRVD") to request that a case be opened to investigate the possible abuse and/or neglect of PQ at HHNH.

I conducted this investigation pursuant to the Protection and Advocacy for Mentally Ill Individuals Act of 1986. My investigation included the following:

1. Interviews with PQ's niece regarding the alleged abuse and/or neglect;
2. Interviews with the HHNH administrator regarding the alleged abuse and/or neglect;
3. Interviews with the Wise County Department of Social Services' Adult Protective Services worker who also investigated the alleged abuse and/or neglect;
4. Review of the State Board of Health's *Rules and Regulations for the Licensure of Nursing Facilities*;
5. Review of PQ's medical record from HHNH;
6. Interview with PQ's physician.

II. BACKGROUND

PQ's niece explained to me before I began my investigation that PQ's mental capacity was limited and that he would not be able to explain how he became bruised. She told me that when she visited him on August 23, 1997, she did not see any bruises but that she did notice that his face was "mangled" with "blood oozing out" following a shave performed by a HHNH staff person and that PQ had burned fingertips from his cigarettes burning too low.

She also told me that, during her August 23, 1997 visit to PQ, the nurse on duty mentioned that a small amount of blood had been found in PQ's stool the night before. PQ's niece said that she was concerned that she was not notified of this sooner.

III. CIRCUMSTANCES SURROUNDING THE INCIDENT

A. August 26, 1997

On August 26, 1997, the same day that PQ's niece requested the assistance of DRVD, she reported to the administrator of HHNH the telephone call that she received from the staff person who found the bruises on PQ. She also went to HHNH to see PQ and the bruises that were reported to her in the telephone call on August 25, 1997.

During that visit, PQ's niece spoke with two nurses who ordinarily assisted PQ with his geri-chair. Both nurses had been on vacation the week before the bruises were found. The nurses speculated that the bruises were a result of the way PQ normally sat in his geri-chair - with his arm hanging over the side of the chair and his head hanging down. The nurses explained that they normally propped a pillow between PQ and his geri-chair to prevent him from bruising. They speculated that, in their absence, the staff person who assisted PQ with his chair had not provided the pillow.

Following her visit to HHNH, PQ's niece telephoned me. She said that the bruises had faded but she was very concerned about the cuts on his face. She also told me that HHNH had obtained an extender for PQ's cigarettes to protect his fingertips.

I contacted the administrator of HHNH and told her that DRVD had received a complaint alleging possible abuse and/or neglect concerning PQ, and advised her that I would be conducting an investigation of the complaint. She told me during our conversation that it was likely that PQ had sustained the bruises from the way he sat in his geri-chair.

As a result of our conversation, the administrator consulted with an occupational therapist to find positions that PQ could sit in his chair that would not result in bruising. PQ was hospitalized three days after this conversation for an unrelated medical condition and did not return to HHNH.

B. August 27, 1997

When I telephoned HHNH's administrator on August 27, 1997, she advised me that PQ's physician had transferred him to the hospital because of a low blood platelet count. A normal platelet count ranges from 150,000 to 450,000; the administrator reported that PQ had a platelet count of 2,000. The administrator told me during our telephone conversation that she believed that PQ's bruises were the result of his low platelet count coupled with the way he slouched when he sat in his geri-chair.

I also contacted PQ's niece. She confirmed that PQ was hospitalized for a low platelet count. She told me that PQ's physician told her that PQ's platelet count could have been responsible for the bruising and the excessive bleeding he experienced when he was shaved.

IV. INVESTIGATIONS BY OTHER AGENCIES

A. Adult Protective Services

On August 26, 1997, I contacted Adult Protective Services ("APS") at the Wise County Department of Social Services to report the possible abuse and/or neglect of PQ. The APS worker visited PQ the same day.

On August 28, 1997, the APS worker called me to report the findings of her investigation. She told me that PQ's bruises were faint and did not resemble fingerprints. She said that she believed that PQ's low platelet count and the position in which he sat in his geri-chair were responsible for his bruises. She also volunteered that she had known PQ for "a long time" and that she did not believe that he was a likely candidate for abuse.

The APS worker expressed some concern regarding three days passing before blood tests were administered for PQ. PQ's HHNH record indicated that he was closely monitored by HHNH staff for additional blood in his stool and none was found. On Monday August 25, 1997, both HHNH and PQ's niece contacted PQ's physician to inform him of the blood found in PQ's stool on August 22,1 997. As a result, PQ's physician scheduled a

consult for PQ on August 29, 1997 with a specialist and authorized blood tests. The blood tests were administered on August 26, 1997 and the findings were telephoned to PQ's physician by HHNH staff later that same day. As a result of the findings, PQ's physician hospitalized him.

On September 5, 1997, I received a letter from the APS worker confirming that her investigation of PQ's bruises and facial bleeding concluded that the allegation of abuse and/or neglect was unfounded.

V. FINDINGS

Based upon my investigation, I also conclude that there is no evidence to substantiate an allegation of possible abuse and/or neglect of PQ by HHNH. PQ's bruises were likely caused by the position in which he sat in his geri-chair coupled with his low platelet count. His facial bleeding can also be attributed to his low platelet count and the resulting inability of his blood to clot. I talked with PQ's physician regarding the low platelet count and he confirmed that a common symptom associated with a low platelet count is bruising and prolonged bleeding from cuts or lacerations due to the blood's inability to clot.

Less easily resolved is PQ's niece's concern that HHNH failed to notify her as soon as blood was detected in PQ's stool. PQ's HHNH record documented that he had been constipated on August 22, 1997 and was given a laxative to relieve his discomfort. Shortly after he was given the laxative, a small amount of blood was found in his stool. There were no further documented reports in PQ's HHNH record regarding blood in his stool. On August 23, 1997, PQ's niece was informed of the blood found in PQ's stool. At that time, PQ's niece told HHNH staff that PQ had a history of hemorrhoids and that she would contact PQ's physician on Monday August 25, 1997 to inform him that blood was found in PQ's stool and that he had a history of hemorrhoids. PQ's HHNH record indicated that the nurse told PQ's niece that HHNH staff would monitor PQ closely and would contact his physician if needed.

My review of the State Board of Health's *Rules and Regulations for the Licensure of Nursing Facilities* revealed that there is no regulation requiring a nursing facility to notify a resident's family or personal representative of a change.

VI. RECOMMENDATIONS

Based upon my investigation, I recommend that:

The State Board of Health's *Rules and Regulations for the Licensure of Nursing Facilities* should be amended to require nursing facility staff to notify a nursing

facility resident's family or personal representative of a change in the resident's medical condition within 24 hours of the change. The amendment should charge the facility administrator with the responsibility for notifying the resident's family or personal representative of the change.